

GUEST EDITORIAL

Ovarian Cancer—1996

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Despite all the progress that has been made in the diagnosis and treatment of cancer, ovarian carcinoma continues to be one of the leading causes of neoplastic-related mortality in the United States. In the annual statistical report by the American Cancer Society, it was estimated that there would be 26,700 new ovarian cancer cases in 1996 with 14,800 deaths [1]. From the Third National Survey, it was estimated that 1 of 70 American women would have ovarian cancer during her lifetime [2]. Ovarian carcinoma continues to be the fourth leading cause of cancer deaths in women during the last several decades [1,3]. Advances in the understanding of various surgical pathologic risk factors led the International Federation of Gynecology and Obstetrics to adopt a new surgical staging system in 1986 [4]. Although significant progress continues to be made in the understanding and treatment of ovarian cancer, long-term survival has not changed significantly. Unfortunately, 5-year survival rates for patients with advanced ovarian cancer are less than 30% [5,6].

Recently, through the joint efforts of the American Cancer Society and the Commission on Cancer, a national cancer data base was created [7]. In addition to identifying differences in treatment patterns, the ovarian cancer patient care evaluation (PCE) study describes disease trends and long-term survival of these patients [8]. In the PCE Study, 1,230 approved hospitals in the United States and Puerto Rico were involved, and a total of 12,316 patients with ovarian cancer were studied. Among these, 5,156 were registered in 1983 and 7,160 patients were registered in 1988. The data were coded and entered by the Division of Cancer Prevention and Control of National Cancer Institute (NCI), and data analysis was done by the American College of Surgeons using the SAS statistical software package. Results of this analysis gave important information regarding the current status and trends for care of women with ovarian cancer in the United States. This survey extracted data from 12,316 ovarian cancer cases, and the data reaffirmed the age distribution of ovarian cancer. Namely, in 50% of patients, ovarian cancer was

diagnosed when they were 55–74 years of age. The diagnosis was made in 80% of patients when they were 45–84 years of age. Thus, this is principally a disease of peri- and postmenopausal patients.

Up to 14% of patients in this study gave a history of multiple malignancies, confirming the importance of screening patients with ovarian cancer for other malignancies of the breasts, colon, and uterus.

Although the symptoms and physical findings of patients with ovarian cancer have not changed significantly in recent years, the application of various diagnostic tests has changed dramatically. Ultrasound and computed tomography (CT) scans of the abdomen and pelvis previously were thought of limited value, but now are found to be more commonly used and of the greatest value. Ultrasound and CT had the highest yields in the 1988 group with positive findings suggesting ovarian cancer in 64–77% of patients. Unfortunately, data from the PCE Study illustrated suboptimal care received by most patients with ovarian cancer. The survey was conducted at hospitals with designated cancer center programs. Patients with cancer often were referred to these facilities because of the availability of various cancer treatment programs, and easy access to the multidisciplinary team of cancer specialists. As such, they can expect to receive better care. For example, it is universally agreed that surgical management of ovarian cancer includes optimal cytoreduction. Because ovarian carcinoma tends to spread intraperitoneally, a total abdominal hysterectomy, bilateral salpingo-oophorectomy, and omentectomy are considered minimum surgical requirements. Data from the PCE Study reveal that only 55–67% of patients underwent abdominal hysterectomy, bilateral salpingo-oophorectomy, and omentectomy. Thus, surgical undertreatment

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patterns persisted from 1983 to 1988 without appreciable change.

Multiple biopsies of peritoneal surfaces, diaphragm, and retroperitoneal lymph nodes are parts of a complete surgical staging system recommended by the International Federation of Gynecology and Obstetrics. Surgical staging repeatedly has been shown to be one of the major prognostic indicators for ovarian carcinoma. Besides omental and adnexal biopsies, it appears that only 12–25% of patients with ovarian cancer had adequate peritoneal, diaphragmatic, and lymph node biopsies to allow accurate surgical staging. Therefore, most of these patients did not undergo the complete surgical staging necessary to assess the extent of disease correctly and facilitate subsequent therapy selection. However, from 1983 to 1988, there was a significant increase in the rates of diaphragmatic, peritoneal, and lymph node biopsies ($P < 0.0001$). We are hopeful that these trends toward more thorough surgical staging will continue.

Also, numerous studies have documented the significance of optimal cytoreduction. Patients whose tumors are debulked successfully to the point of minimal residual disease (i.e., <1 – 2 cm) have been shown to have a better response to chemotherapy and improved survival rates. Approximately 25% of patients underwent optimal cytoreductive surgery. However, the extent of cytoreduction was unknown in 45–50% of patients. Although gynecologic oncologists performed more radical operations, currently it is not known to what extent they contributed to the overall number of optimally debulked cases. Chemotherapy is advocated particularly for patients with advanced disease after optimal cytoreduction. In the national

survey, 67% of patients with ovarian cancer received adjunctive chemotherapy.

After initial surgery and chemotherapy, 22.9% of patients underwent a second-look operation. Formerly, second-look laparotomy was advised for patients without radiologic or clinical evidence of disease after having completed a planned course of chemotherapy. The current trend is to reserve second-look laparotomy only for those patients in whom adjunctive therapy would be advised based on a planned study protocol in the evaluation of new chemotherapeutic trials.

Advanced-stage ovarian cancer continues to carry a poor prognosis. Because progress in the treatment of ovarian cancer has not resulted in improved long-term survival rates, efforts must be made in the areas of cancer screening and early detection, to reduce the number of ovarian cancer deaths.

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